Before the
Federal Communications Commission
Washington, DC 20554

In the Matter of)
Rural Health Care)
Support Mechanism) WC Docket No. 02-60

Comments of
Iowa Health System

Introduction and Background. Iowa Health System (IHS) welcomes the opportunity to comment on the Federal Communications Commission?s (FCC?s) Notice of Proposed Rulemaking released July 15, 2010.

Iowa Health System is the largest health system in Iowa and western Illinois, with 14 urban affiliate hospitals, 11 network rural hospitals, over 120 physician clinics and numerous home health providers. IHS provides service to over 70 communities in Iowa, eastern Nebraska and western Illinois. In addition, over 2,600 physicians are on the active medical staffs of our facilities. Our integrated group of hospitals and physicians see patients reap the benefits of system interoperability and sharing of health information on a daily basis. These comments reflect the recommendations of our physician clinics, hospitals and other providers who seek to have the complete ability to share health information via electronic means in all areas of the state in order to provide our patients with the highest quality care at the lowest cost, regardless of where they live.

As further background, we consider our urban hospitals and physicians somewhat ahead of the curve when it comes to the ability to share information throughout the system. This is largely due to the fact that IHS is in a unique position for a health system. IHS owns over 2100 miles of state-of-the art fiber optic network and has dedicated access on an additional 1100 miles of private fiber network connecting to metro Chicago and Denver. This underlying physical network is comprised of six fiber strands, two in use for the IHS internal network, two in use for the HealthNet connect network (funded in part by the Federal Communication Commission?s Rural Health Care Pilot Project) and two for the planned BTOP network (funded in part by the American Recovery and Reinvestment Act of 2009 (ARRA) Broadband Technologies Opportunity Program (BTOP) program of the US Department of Commerce, National Telecommunications and Information Administration).

The IHS network serves IHS-affiliated entities. HealthNet connect serves healthcare-related entities pursuant to the rules of the FCC pilot program, and BTOP expands network service possibilities to

other healthcare providers, including physicians, and non-healthcare community anchor institutions, including public safety agencies, municipalities, counties, community colleges and universities.
It is the goal of Iowa Health System to provide a network platform to our affiliated and non-affiliated entities that will facilitate regional/population-based care where all health care providers and other health care related entities can share pertinent health information. To do so, requires dependable and secure broadband connections with sufficient bandwidth capable of carrying vast amounts of information.
Our network has begun this connection within the IHS network, and a substantial number of IHS hospitals and physicians are connected. The efforts have been continued through the FCC?s Rural Health Care Pilot Project. In the first phase, which has now been completed, 28 rural healthcare facilities were connected to the network. During the second phase of the project, which we are in now, 31 additional rural healthcare facilities will be connected to the network.
BTOP funding provides the opportunity to add many additional healthcare providers to the network including solo physician practitioners, federally qualified health centers, home health care agencies, hospice providers, pharmacies, private payers, device and biotech companies and other private healthcare related vendors. It is this type of connected electronic information infrastructure which is an essential ingredient for survival and success of healthcare providers under the preferred models of healthcare, such as an accountable care organization, as set forth in the Patient Protection and Affordable Care Act (PPACA).

Many of these clients will use wireless tower capacity or long haul fiber connectivity to major carrier ?meet me? locations in Chicago and Denver which will bring the benefits of metro Network Access Points (NAPs) to rural Iowa. These wireless tower and NAP elements will only be possible due to BTOP funding rules and requirements.

In light of these factors, a summary of our comments and recommendations are:

? Remove barriers to the delivery of healthcare by expanding the entities who are considered eligible providers. For example, we believe that for-profit entities that can reasonably demonstrate that their purpose is related to the provision of health care in our communities be eligible to receive RHCPP funding for connections, which will enable for-profit healthcare related traffic to travel over RHCPP-funded connections.
? Eliminate excess administrative burdens such as requiring proof that broadband services are insufficient ? services are expensive or not available today because infrastructure is lacking in rural areas.
? Focus grant funding on the creation of new infrastructure - continued focus on subsidizing existing services does not move healthcare where it needs to be. We need to create new, modern, efficient, competitive and affordable infrastructure and focus those efforts on our most vulnerable populations.

? Incidental use of the RHCPP network which is conducted as a part of BTOP funding projects should be allowed as long as the use is conducted in compliance with BTOP funding.

IHS Specific Comments.

15. Initial Application. In IHS? opinion, an applicant should have considerable detail worked out on a specific project prior to filing an application. In light of this assumption, it would seem reasonable to ask that the initial application process require that some of the information from the project commitment phase be included in the initial application. We propose that an applicant secure all participant commitments and perform all the investigation, complete the design and complete the economic sustainability analysis prior to actually submitting the initial application. This information should be required at the time of the initial application. This important information would then be available for use in determining whether an applicant has capacity to undertake and perform the project, whether a particular project is sustainable and whether or not a grant should be awarded. If a more comprehensive application is required initially, notice of acceptance or rejection should be made within 90 days of the initial application deadline.

Conversely, we think that requiring letters of agency during the initial application is not realistic and would unduly limit the ability of a project to qualify. An applicant would be required to show a legal commitment prior to receipt of funding. A commitment letter which declares a contractual commitment to the project should suffice for the initial application.

17. Project Commitment Phase. See comments per paragraph 15.

19. Demonstration of unavailability. Data on the availability and pricing of anything other than mass-market, end user products is largely unavailable. Information services are not subject to tariff filings or regulation and are generally sold on an individual case-by-case basis. What services are available are location specific, price specific and time-for-delivery specific for each location, and require potential users to place an order before pricing will be specified. 10 Mbps or greater services are not available in most rural areas without the creation of new infrastructure, either carrier or private. The State of Iowa is nearing completion of a mapping process that was funded through the American Reinvestment and Recovery Act.

20. Connectivity Speed. IHS urges the FCC to consider requiring higher connectivity speeds as a prerequisite for distribution of these grant moneys. 100 Mbps is the minimum required for current and planned healthcare applications where video services are involved. A more realistic, forward looking target is 1 Gbps for each location, allowing multiple video and data streams for more than one use at a time. It has also been our experience that carrier offerings are based on shared bandwidth, not guaranteed bandwidth, meaning that a 10 Mbps offering from, e.g., a cable company, is in reality, significantly less than 10 Mbps of usable bandwidth.

23. Financial Analysis. Typical depreciable life for fiber construction is 20 to 25 years, electronics 5-7 years, and buildings/poles 25-30 years. The ARRA/BTOP program used a present value analysis over the life of the project (generally 15-20 years). This requirement seems reasonable assuming sufficient data is available.

26. Letters of Agency. While commitment from multiple participants is necessary before commitment of funding, it seems unreasonable to make this a part of the initial applications process, which is nine or more months from funding commitment. Assuming that the FCC rules stay with the multiple phase application process then there is no reason to require ?commitment? from participants before there is commitment from the government to make the grant. See comments on sections 15 and 17 above.

30. Cap on amount funded per project. Infrastructure projects are capital intensive and expensive in the short term, even though they may be justifiable over the long term (see comments on section 23 above). Any cap should be a per-year cap not a project cap or a per applicant cap.

31. Cap on number of projects per year. For administrative purposes the FCC should focus on approving the ?best? projects each year rather than maximizing or minimizing the number and size of the projects. Most infrastructure projects are likely to be multi-year projects so it would seem logical to commit to multi-year funding for those projects.

37. Administrative expenses. The limit is too low. Given the complexity of the application process, the grant program and the reporting and audit requirements, one full-time-equivalent is not enough to accomplish all the required tasks. The limit should be $300,000 per year, noting that this still obligates the applicant to $45,000 per year for the 15% match.

39. Maintenance costs. Infrastructure projects are long-term projects with long-term maintenance requirements. The inability to generate sufficient funds for long-term sustainability is the reason these networks do not exist in rural areas. Government funding of maintenance should be equal to the life of the infrastructure deployed: 15 to 20 years in most cases.

42. Ineligible costs. IHS urges the FCC to reconsider the inclusion of connections to for-profit entities in the category of ?ineligible costs?. As an example, this prohibition would prevent recipients from connecting a for-profit multi-specialty physician clinic, a pharmacy, a for-profit insurance company, a for-profit durable medical equipment company, a for-profit hospice entity, or a for-profit home health care entity from using RHCPP funds to connect with our regional health care network. This prohibition is significant because a typical patient encounter will involve the provision of care by many of these entities. Many of the initiatives, such as accountable care organizations, depend on the ability to share information quickly between these types of entities and this prohibition is a substantial

obstacle to achieving the goal of seamless provision of care for patients nationwide. Accordingly, we propose that for-profit entities that can reasonably demonstrate that their purpose is reasonably related to the provision of health care in our communities be eligible to receive funding for connections to our regional health care network and for for-profit related traffic to be able to traverse RHCPP-funded connections.

43. Billing and operational expenses. We urge the FCC to include a broad definition of operational expenses and include such items as moves, adds, changes, network monitoring, problem resolution, repairs, power costs, etc, within the definition. Such funding will provide needed assistance in covering operational costs which furthers the purposes of the health care provisions of the National Broadband plan.

47. Eligible Sources. In general, IHS would argue against an extensive list of exclusions for eligible matching funding. As long as the primary purpose for which the funds are sought under the grant program are consistent with the goal of improving rural healthcare, there should be minimal limitation on eligible matching sources.

Specifically, the proposed regulations prohibit the use of in-kind donations for meeting minimum contributions. This prohibition will prevent applicants from activities such as trading fiber optic cable. Additionally, other federal grant programs allow the use on in-kind contributions, including the ARRA. We propose that award recipients be permitted to use in-kind donations to further program objectives.

This section would also prohibit contributions from for-profit entities. It is critical to the concept of creating a health care network to include for-profit entities. For example, a patient receiving care may begin at a for-profit physician clinic, be sent to a nonprofit hospital for digital x-rays, then sent to a for-profit retail pharmacy, and then all billing information sent to their for-profit insurance carrier. The relevant factor in the analysis of funding should be not where the funding comes from, but what the purpose of the funding is. As evident from the example, the for-profit entities are a crucial part of the connectivity of healthcare in this nation. This focus moves away from the reason for this entire proposal, the patient.

59. Depreciation of network components. Sustainability plans include equipment replacement as it reaches the end of its useful life. IHS supports the use of standard (GAAP) accounting methodology, including the use of depreciation reserves. As a practical matter, it should be noted that ownership and operation of network infrastructure is oftentimes best accounted using the applicants? subsidiaries or affiliates. Since ultimate control and responsibility remain with the applicant, IHS recommends no prohibition on transfers to such entities.

69-75. Fully-distributed and incremental costs. Cost allocation

ultimately depends on use and potential capacity, not incremental construction costs. Where multiple users share common cable, IHS recommends allocating costs based on total fiber count. This allocation methodology has the advantage of simplicity, especially where the ?excess? fibers are lit by the sharing user with that user?s only electronics.

Our recommendation recognizes several characteristics of shared use. First, even a single pair of optical fiber strands in a fiber optic based network have almost unlimited capacity (multiple Tbps). A determination of ?excess? capacity is subject to interpretation and is dependent on how the fiber is lit(i.e. what electronics are installed), as well as how many fibers are available. Second, the nature of wired network construction is such that the physical network placement costs are the predominant costs of the project and the fiber cable itself has a decreasing marginal cost structure. Third, by definition, the allocation of costs is arbitrary and dependent upon assumptions used. In the telecommunications industry, the cost allocation methodology used to determine access charges and other support mechanisms has spawned an entire industry of consultants, specializing in cost allocation, cost studies and related matters. Since healthcare providers, not telecom companies will be the primary applicant pool for the FCC?s grant program, healthcare providers will be unprepared and ill-equipped to handle this enormous regulatory burden and its financial cost as ineligible administrative expense.

77. Excess capacity disclosures. IHS recommends eliminating detailed and specific cost allocation and capacity sharing requirements from the rules. As noted in comments 69-75, excess capacity depends entirely on how excess is defined. Too narrow or restrictive definitions of capacity and cost allocation will severely limit and applicant?s ability to create long-term sustainability to support its healthcare network. To illustrate, let?s assume capacity is defined as useable bandwidth. For a network infrastructure based on multiple fiber strands in a common cable, an applicant that only lights a pair of fiber for its own use would have zero excess ?capacity? until additional fiber are lit. Alternatively, for a network that cannot be sustained through healthcare use alone, an applicant could sell IRU?s to unrelated (ineligible) third parties and ?excess capacity? could be defined as extra (unlit) fiber strands in the same cable.

78. Community Anchor Institutions. To coordinate with other federal funding priorities and in recognition that certain public uses have similar broadband infrastructure needs, IHS supports the use of additional capacity for community use. For instance, high-speed connectivity, dedicated bandwidth, and increased security measures are also crucial for public safety institutions. IHS would refer the FCC to eligible community anchor institutions prioritized in the Round 2 BTOP grant program. It should be noted that healthcare projects should remain the focus of the FCC program and that other community uses should not detract from healthcare project sustainability.

85-86. Competitive bidding. The RHCPP relied on USAC postings for 28 days, and many of the

postings included detailed RFP. Vendors in this space are familiar with this posting and response process, and there is no reason to require applicants to incur increased administrative (and non-reimbursable) costs by requiring extensive publication elsewhere. In addition, the $100,000 exclusion from the RFP process is too low. The limit should be raised to $500,000. There should also be allowance for sole-source contracts for services in project management and network operation and maintenance, since many applicants already have contractual relationships with third parties for operation and maintenance of their existing networks.

89. NEPA and NHPA. Compliance with these requirements should generally follow similar requirements to those imposed by ARRA/BTOP/BIP programs, but should not require completion before funds are made available under the FCC grant program. Compliance is expensive and time consuming; costs for compliance should be considered eligible costs.

HEALTH BROADBAND SERVICES PROGRAM

95. Access to advanced telecommunications and information services. IHS agrees that the health services program should not be limited to public internet. It is crucial for health care providers to have assistance with the costs of access to the technology necessary to post data, interact with stored data, generate new date and communicate over private networks as well as public internet.

97. Minimum Broadband Capability. As stated in our comments under paragraph 20, IHS urges the FCC to consider requiring higher connectivity speeds as a prerequisite for distribution of these grant moneys. 100 Mbps is the minimum required for current and planned healthcare applications where video services are involved. A more realistic, forward looking target is 1 Gbps for each location, allowing multiple video and data streams for more than one use at a time. It has also been our experience that carrier offerings are based on shared bandwidth, not guaranteed bandwidth, meaning that a 10 Mbps offering from, e.g., a cable company, is in reality, significantly less than 10 Mbps of usable bandwidth.

98. Eligible Service Providers. We are supportive of the traditional approach utilized by the FCC to allow participants in the health broadband services program to seek supported services from any type of broadband provider, as long as the participant selects the most cost-effective option to meet its health care needs.

113. Opting into the Health Broadband Services Program. IHS supports allowing pilot program participants whose original request for competitive bids included both non-recurring and recurring costs to be permitted to transition to
the health broadband services program without undergoing a new competitive bidding process. We do not see a sufficient policy reason to duplicate efforts by requiring additional competitive bids.

ELIGIBLE HEALTH CARE PROVIDERS

115. General Comments. IHS believes that the list of eligible providers should be expanded as much as possible to include all player?s in the health care arena, regardless of the way they are configured for business or taxation purposes. For example, for-profit physician?s clinics and physician?s offices should be included as eligible health care providers. To leave out this key area of health care providers is inconsistent with the meaningful use requirements that will penalize these very providers in 2015 if they are not utilizing EHR. We believe it is crucial to recognize the interconnection and integral role that for-profit health care providers play in the health care universe.

The National Broadband Plan recognized the need for consideration of for-profit providers, particularly those that work with vulnerable populations. We wholeheartedly agree that this source of funding under the broadband services program should be focused on vulnerable populations ? we would offer a definition of ?vulnerable population? that includes rural, elderly, and medically underserved and that if Congressional action is needed to provide authority to expand the list of eligible providers, then it should be supported.

IHS provided evidence of the vulnerability of the area that we proposed to serve when applying for the BTOP grant and argued that the project?s ability and plan to serve these groups justifies the investment of federal funds.

?Rural: Iowa is a rural agricultural state with almost 3 million residents. Iowa ranks 35 in the country in terms of population density. Of Iowa?s 99 counties, only 20 counties are classified as metropolitan areas. Physical distance leaves rural residents geographically vulnerable. In addition, pre-recession indicators from 2007 show that non-metro incomes were 84.6% of metro incomes (a difference of $5000 per capita) and that all counties with unemployment rates in excess of the national average were classified as rural. High-speed broadband service can negate some distance barriers.

Elderly: Iowa?s residents are among the oldest in the nation. In 2007, 14.7% of Iowans were at least 65 years of age (5th in the US) and 2.59% were at least 85 years old (3rd in the US). The continued aging of Iowa is projected to increase at a rate higher than the national level. By 2030, 22.4% of Iowans will be seniors and 84 Iowa counties will have at least a 20% senior population. Elderly disproportionately reside in rural areas, comprising 25.4% of residents. Elderly populations are vulnerable ? many are on fixed incomes, have physical and mental limitations and require supplemental services for daily living activities. Affordable access to high-speed broadband supports services for seniors and their specific needs.

Medically Underserved: High-speed broadband service permits expanded use of distance learning, telehealth services, and electronic medical records sharing. Broadband will provide direct healthcare services and assist with recruitment and retention of healthcare professionals. The need for direct health services is great. In Iowa, 38% of residents have at least one chronic disease (Lewin Group, 2007). Iowa?s mortality rates for the top three chronic conditions (Heart Disease, Stroke, and All Cancers) exceed national averages (CDC, 2007). Other notable chronic health indicators for Iowans include colorectal cancer mortality, COPD mortality for age 45 and older, mental disorder mortality,

and obesity. These acute conditions often require emergency care, hospitalization and follow-up care. Of Iowa?s 99 counties, 56 counties are classified in whole or in part as medically underserved areas, and only 6 are metropolitan counties (HRSA, 2008). In total, there are 80 designated medically underserved areas in Iowa. Iowa ranks 44th overall in providing access to primary care physicians. An Iowa Department of Public Health study finds that, to ensure every Iowan has access to health care, at least 250 more providers are needed in underserved communities. The report estimates that nearly 242,000 Iowans will lack reliable access to care by 2015. In addition, Iowa ranks in the lower 10% for certain specialists, including neurosurgeons and psychiatrists.?

Whatever entity provides health care for a vulnerable population, however that is determined, should be eligible for funding regardless of how that entities? business structure has been configured. The point of the fund is to get health care where it is needed the most.

118 and 119. Off-site administrative offices. IHS agrees with this proposal. Off-site and on-site administrative offices should be treated the same when they otherwise perform the same functions. It is impractical to distinguish administrative offices located off-site versus those located on-site. The proposal to require that at least 51 percent be owned or controlled by an eligible non-profit or public health care provider is reasonable. If the off-site office is not owned at least 51% by the eligible health care provider, there is no guarantee that the services would be used long-term for health care purposes. We would not support allowing any funding for an office that is less than 51% ownership. We agree that funding should be allowed for eligible health care providers who seek support for off-site administrative offices only in those instances where the health care provider certifies that the administrative office is used primarily for performing services that are integral to the provision of health care by eligible health care providers.

121 and 122. Off-site data centers. IHS agrees with the comments that it is impractical to disallow funding to data centers that provide the same function as on-site entities, just because they happen to be located off-site. The paramount issue is patient care and how is that best delivered. Whether the data center is on-site or off-site, both promote the adoption of HER and meaningful use requirements.

123 & 126. Skilled Nursing Facilities & Renal Dialysis Centers and Facilities . IHS agrees that these facilities should be considered eligible providers

143 and 144. Meaningful Use as a condition of compliance . IHS does not agree that receipt of rural health care support should be conditioned on a providers? compliance with HHS meaningful use requirements. It is the very rural health providers that this program is meant to assist, that would be most penalized by imposing meaningful use criteria. We believe that the incentives and disincentives built into HHS? ?meaningful use? policy are sufficient to further the goals for which is was

implemented. Conditioning receipt of these funds on its use will be at cross-purposes to the goals of this program. We also believe that requiring documentation of meaningful use for a segment of the potential applicants, physicians and hospitals, imposes burdens on that sector without commensurate burdens on other applicants.

Thank you for this opportunity to share our comments and recommendations. If you have specific questions regarding our submission, please contact Sabra Rosener, VP Government Relations at Rosenesk@ihs.org .

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